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	17E210	A. BUILDING _____ B. WING _____	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW MANOR OF PEABODY	**500 PEABODY PEABODY, KS 66866**

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #71010. A revised copy of the 2567 was sent to the provider on 1/16/14.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility had a census of 47 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to revise the care plan for 1 of 12 residents when staff applied a wanderguard bracelet for safty concerns. (#45)	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 280	Continued From page 1 Findings included: - The 12/4/13 physician orders indicated Resident # 45 had diagnoses that included: Psychosis (any major mental disorder characterized by a gross impairment in reality testing)and Bipolar Disorder (a major mental illness that causes people to have episodes of severe high and low moods). The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 11/24/13, indicated the resident understands others and is understood by others, and had adequate vision glasses. The MDS indicated the resident scored 14 on the (BIMS), Brief Interview for Mental Status, which indicated intact cognition and displayed physical behaviors directed toward others. The 12/2/13 care plan stated the resident was leaving the facility grounds without staff around and going onto the neighbor's property. The care plan indicated the resident was unable to go to town without staff, related to diagnosis of psychosis and bipolar disorder with inappropriate behavior. The care plan instructed staff to monitor the resident for increased anxiety, increased psychosis, and place him/her on visual checks by the charge nurse, who would determine how often checks were to be done. The care plan instructed the staff to explain the reason he/she was not to leave the facility grounds without staff and risks of doing so to the resident. The care plan also instructed the staff, if the resident was not in the building or on the facility grounds on routine visual checks, the staff would look for the resident on the facility's neighboring property and also look downtown. The care plan further stated if the staff were unable to locate the resident, the staff would call 911, notify the facility's Administrator, resident's family/guardian, and	F 280		

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F 280	Continued From page 2	F 280		

physician. If necessary, nursing will request an order for a wanderguard bracelet as needed to prevent the resident from leaving the facility grounds. (A wanderguard bracelet is a device that is worn by a wandering resident in a facility to alert the staff a resident is attempting to go out an exit door)

Review of the medical record revealed the resident had left the building on several occasions to walk around the building and also had left the facility's property.

The 12/30/13 at 10:30 AM, nurse's notes indicated the resident left the facility grounds with only a long sleeved shirt on and the staff left to retrieve the resident but the resident returned on his/her own, within 5 minutes. The staff received a physician's phone order for a wanderguard bracelet to be placed on the resident for safety and the staff placed the wanderguard on the resident's right ankle. (The temperature was approximately 19.4 degrees with 13.8 mile per hour winds from the south southwest and scattered clouds when the resident left the building.)

The 12/30/13 physician's order instructed the staff to place a wanderguard bracelet on the resident for safety to prevent the resident from walking off the facility grounds, or going to town when on a walking restriction.

Further review of the medical record revealed no care plan update instructing the staff to ensure the resident had the wanderguard bracelet on at all times.

On 1/7/14 at 9:39 AM, observation revealed the resident dressed in pajamas lying on his/her bed

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F 280	Continued From page 3 with a wanderguard around his/her right ankle. On 1/7/14 at 4:02 PM, Administrative Nurse A verified the staff had not updated the care plan after applying the resident's wanderguard. On 1/7/14 at 4:40 PM, Administrative Staff H stated the resident only has a wanderguard bracelet on due to going outside in a long sleeved shirt only and no coat. Administrative Staff H stated when the weather warms up the wanderguard will come off and the wanderguard bracelet is not added to the resident's care plan when it is used only temporarily. The facility failed to revise the care plan to inform the staff that Resident # 45 now had a wanderguard bracelet on due to his/her lack of safety awareness including wearing inappropriate clothing for the temperature outside.	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 4 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 47 residents. The sample included 12 residents of which 5 residents were reviewed for unnecessary medication. Based on observation, record review and interview, the facility failed to ensure 2 of 5 residents were free of unnecessary medications. The facility failed to obtain Resident #20's blood pressure prior to medication administration as ordered by the physician and failed to notify Resident #40's physician of outside parameters as set by the physician Findings included: - Resident #20's quarterly (MDS) Minimum Data Set 3.0 assessment dated, 11/20/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 which indicated intact cognition. The assessment revealed the resident independent with all activities of daily living, and he/she had not displayed any behaviors during the assessment period. The updated 11/25/13 plan of care directed the charge nurse to administer medication as ordered by the physician. The plan of care further directed the charge nurse to obtain the resident's blood pressure weekly and more often if deemed necessary to monitor for hypertension (high blood pressure).	F 329		

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F 329	Continued From page 5 The 12/4/13 physician's order directed the staff to hold the Lisinopril (medication for hypertension) 5 mg (milligram) at bedtime if the SBP (Systolic Blood Pressure) is less than 100. Review of the resident's MAR (medication administration record) for January 2014, December 2013, November 2013, October 2013, September 2013, and August 2013 revealed the resident's blood pressure had not been obtained prior to administering the Lisinopril at bedtime which had been indicated on the MAR to do so. On 1/7/14 at 9:15 AM, observation revealed the resident independently ambulating down the hall. On 1/8/14 at 2:40 PM, Nurse C verified the physician's order was currently for obtaining the resident's blood pressure prior to administering the Lisinopril was on the MAR, although he/she thought it had been discontinued. Nurse C stated he/she had only been obtaining the resident's blood pressure weekly. On 1/8/14 at 2:40 PM, Administrative Nurse A verified there had not been an order from the physician to discontinue obtaining the blood pressures prior to medication administration and would expect the staff to follow the physician orders. The facility's December 2009 Specific Medication Administration Procedure directed the staff to check the MAR for the order. The procedure further directed the staff to obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration.	F 329		

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F 329	Continued From page 6 The facility failed to obtain the resident's blood pressure prior to administering medication as ordered by the physician. (#20) - Resident #40's annual (MDS) Minimum Data Set 3.0 assessment, dated 11/4/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 which indicated intact cognition. The assessment revealed the resident independent with all activities of daily living, and he/she had not displayed any behaviors during the assessment period. The updated 11/11/13 plan of care directed the staff to encourage the resident to rise up slowly when getting up from the bed or chair. The plan of care further directed the staff to encourage the resident to use the handrail in the hallways if unsteady on his/her feet. The 12/4/13 physician's order directed the staff to notify the physician if the resident's blood pressure was less than 130/80 when administering Norvasc (a blood pressure medication) 10 mg (milligrams). Review of the MAR (Medication Administration Record) revealed the staff had not been obtaining the resident's blood pressures prior to administering the Norvasc but had been obtaining the blood pressures. Further review of the record revealed multiple blood pressures that were out of the parameters as set by the physician and the staff had administered the medication. The medical record revealed no documentation the staff notified the physician of resident's blood pressure when outside of the parameters. Review of the weekly vital sheet revealed the resident's blood pressures were:	F 329		

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F 329	Continued From page 7 1/1/14 - 120/78 12/25/13 -118/74 12/11/13 - 104/70 12/4/13 - 114/76 11/21/13 - 119/85 10/30/13 - 111/72 10/23/13 - 128/78 10/9/13 - 124/78 10/2/13 - 120/80 On 1/7/14 at 12:00 PM, observation revealed the resident seated at the dining table eating independently. On 1/8/14 at 2:33 PM, Nurse C stated he/she was unsure if the physician had been notified regarding the blood pressure's out of the physician's parameters. Nurse C further stated that if it is not charted in the nurse's note's, then the physician had probably not been notified. On 1/8/14 at 2:45 PM, Administrative Nurse A stated the charge nurse is to fill out the facility's S Bar (a form filled out by the nurse regarding information to be faxed to the physician) sheet and send a fax to the physician if the resident's blood pressure's are out of the parameters and then the staff are to chart it in the nurse's notes. Administrative Nurse A further stated he/she would expect staff to follow the physician orders. Review of the facility's S Bar forms and resident's medical record revealed no documentation the staff had notified the physician of the blood pressures outside of the set parameters. The facility's December 2009 Specific Medication Administration Procedure directed the staff to check the MAR for the order. The procedure	F 329		

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F 329	Continued From page 8 further directed the staff to obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. The facility failed to obtain Resident #40's blood pressure prior to administering medication as ordered by the physician and failed to notify the physician regarding the resident's blood pressures that were out of the parameters as set by the physician.	F 329		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This Requirement is not met as evidenced by: The facility had a census of 47 residents. The sample included 12 residents. Based on record review and interview, the facility failed to provide a Registered Nurse 8 consecutive hours a day, 7 days a week for the 47 residents who reside in the facility. Findings included: - Review of the October, November, December	F 354		

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F 354	Continued From page 9 2013 and the January 2014 (through 1/9/14) licensed nursing schedule revealed the lack of a Registered Nurse coverage for 8 consecutive hours on the following dates: 1) October 2013-10/3/13, 10/4/13, 10/5/13, 10/6/13, 10/12/13, 10/13/13, 10/19/13, 10/20/13, 10/26/13 and 10/27/13. (10 times) 2) November 2013-11/2/13, 11/3/13, 11/9/13, 11/10/13, 11/16/13, 11/17/13, 11/23/13, 11/24/13. 11/29/13 and 11/30/13. (10 times) 3) December 2013-12/1/13, 12/7/13, 12/8/13, 12/11/13, 12/12/13, 12/13/13, 12/14/13, 12/15/13, 12/20/13, 12/21/13, 12/22/13, 12/23/13, 12/24/13, 12/25/13. 12/26/13, 12/27/13, 12/29/13. (17 times) 4) January 2014-1/1/14, 1/4/14, 1/5/14 (3 times) On 1/8/14 at 2:30 PM, Administrative Nurse A verified the facility did not always have 8 consecutive hours of RN coverage on a daily basis. The facility failed to provide a Registered Nurse for 8 consecutive hours to the 47 residents who reside in the facility.	F 354		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This Requirement is not met as evidenced by:
The facility had a census of 47 residents. The sample included 12 residents. Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions for the 47 residents who receive meals from 1 of 1 kitchen.

Findings included:

- On 1/8/14 at 11:45 AM, observation during the noon meal, revealed Dietary Staff G dropped a potholder on the floor in the kitchen. Further observation revealed Dietary Staff G picked up the pot holder as he/she was opening the oven door and used the soiled pot holder to take out a pan of swiss steak from the oven.

On 1/8/14 at 11:50 AM, observation revealed Administrative Staff H entered the kitchen without a hairnet, crossed the red line by the food prep area, and took a cart out of the kitchen to the dining room area. The red line on the kitchen floor is to indicate how far you may enter the kitchen without a hairnet.

On 1/8/14 at 12:00 PM, Dietary Staff G stated he/she knew the potholder had fallen on the floor and he/she verified the potholder was soiled and should not have been used.

On 1/8/14 at 12:00 PM, Dietary Staff F stated the staff have been trained regarding infection control issues and verified the staff should have put the potholder in a basket for dirty linens. Dietary Staff F further stated that the red line on the kitchen floor is not to be crossed without having a hairnet

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F 371	Continued From page 11 on. The facility failed to distribute and serve food under sanitary conditions for the 47 resident who resided in the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility had a census of 47 residents. The sample included 12 residents of which 5 were reviewed for unnecessary medication. Based on observation, record review and interview, the facility's pharmacy consultant failed to notify the facility regarding the staff not obtaining the resident's blood pressures upon administration of medication or blood pressures outside of parameters as ordered by the physician for 2 of 5 residents.(#20, #40) Findings included: - Resident #20's quarterly (MDS) Minimum Data Set 3.0 assessment dated, 11/20/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 which indicated intact cognition. The assessment revealed the resident	F 428		

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F 428	Continued From page 12	F 428		

independent with all activities of daily living, and he/she had not displayed any behaviors during the assessment period.

The updated 11/25/13 plan of care directed the charge nurse to administer medication as ordered by the physician. The plan of care further directed the charge nurse to obtain the resident's blood pressure weekly and more often if deemed necessary to monitor for hypertension (high blood pressure).

The 12/4/13 physician's order directed the staff to hold the Lisinopril (medication for hypertension) 5 mg (milligram) at bedtime if the SBP (Systolic Blood Pressure) is less than 100.

Review of the resident's MAR (medication administration record) for January 2014, December 2013, November 2013, October 2013, September 2013, and August 2013 revealed the resident's blood pressure had not been obtained prior to administering the Lisinopril at bedtime which had been indicated on the MAR to do so.

Review of the Pharmacy Consultation records for 12/23/2013, 11/27/2013, 10/23/13, and 9/19/2013 revealed no irregularities for the resident.

On 1/7/14 at 9:15 AM, observation revealed the resident independently ambulating down the hall.

On 1/8/14 at 2:40 PM, Nurse C verified the physician's order was currently for obtaining the resident's blood pressure prior to administering the Lisinopril was on the MAR, although he/she thought it had been discontinued. Nurse C stated he/she had only been obtaining the resident's blood pressure weekly.

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F 428	Continued From page 13 On 1/8/14 at 2:40 PM, Administrative Nurse A verified there had not been an order from the physician to discontinue the blood pressures prior to medication administration and would expect the staff to follow the physician orders. The facility's December 2009 Specific Medication Administration Procedure directed the staff to check the MAR for the order. The procedure further directed the staff to obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. The facility's pharmacist failed to notify the facility of the staff not obtaining the resident's blood pressure prior to administering medication as ordered by the physician. (#20) - Resident #40's annual (MDS) Minimum Data Set 3.0 assessment, dated 11/4/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 which indicated intact cognition. The assessment revealed the resident independent with all activities of daily living, and he/she had not displayed any behaviors during the assessment period. The updated 11/11/13 plan of care directed the staff to encourage the resident to rise up slowly when getting up from the bed or chair. The plan of care further directed the staff to encourage the resident to use the handrail in the hallways if unsteady on his/her feet. The 12/4/13 physician's order directed the staff to notify the physician if the resident's blood pressure was less than 130/80 when administering Norvasc (a blood pressure medication) 10 mg (milligrams).	F 428		

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	17E210	A. BUILDING _____ B. WING _____	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW MANOR OF PEABODY	500 PEABODY PEABODY, KS 66866

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F 428	Continued From page 14 Review of the MAR (Medication Administration Record) revealed the staff had not been obtaining the resident's blood pressures prior to administering the Norvasc but had been obtaining the blood pressures weekly. Further review of the record revealed multiple blood pressures that were out of the parameters as set by the physician and the staff had administered the medication. The medical record revealed no documentation the staff notified the physician of resident's blood pressure when outside of the parameters. Review of the weekly vital sheet revealed the resident's blood pressures were: 1/1/14 - 120/78 12/25/13 -118/74 12/11/13 - 104/70 12/4/13 - 114/76 11/21/13 - 119/85 10/30/13 - 111/72 10/23/13 - 128/78 10/9/13 - 124/78 10/2/13 - 120/80 Review of the Pharmacy Consultation sheet for 12/23/2013, 11/24/2013, and 10/23/13 revealed no irregularities for the resident. On 1/7/14 at 12:00 PM, observation revealed the resident seated at the dining table eating independently. On 1/8/14 at 2:33 PM, Nurse C stated he/she was unsure if the physician had been notified regarding the blood pressure's out of the physician's parameters. Nurse C further stated that if it is not charted in the nurse's note's, then the physician had probably not been notified.	F 428		

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F 428	Continued From page 15 On 1/8/14 at 2:45 PM, Administrative Nurse A stated the charge nurse is to fill out the facility's S Bar (a form filled out by the nurse regarding information to be faxed to the physician) sheet and send a fax to the physician if the resident's blood pressure's are out of the parameters and then the staff are to chart it in the nurse's notes. Administrative Nurse A further stated he/she would expect staff to follow the physician orders. Review of the facility's S Bar forms and resident's medical record revealed no documentation the staff had notified the physician of the blood pressures outside of the set parameters. The facility's December 2009 Specific Medication Administration Procedure directed the staff to check the MAR for the order. The procedure further directed the staff to obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. The facility's pharmacy consultant failed to notify the facility regarding the staff not obtaining Resident #40's blood pressures upon administration of medication as ordered by the physician and the failure to notify the facility of a resident's blood pressures out of the parameters as set by the physician.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 16 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 47 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection of the 47 residents residing in the facility.	F 441		

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F 441	Continued From page 17 Findings included: - On 1/07/2014 at 9:35 AM, observation revealed Housekeeping staff B applied gloves and preceded to spray a resident's sink and toilet with a mixture of Lysol and water, then immediately wiped the sink and toilet with a white cloth rag. Housekeeping staff B then sprayed the mirror with a generic window cleaner spray. Housekeeping staff B used Comet to clean the inside of the toilet, and sprayed the Eco lab lemon lift (a heavy duty cleaner and destainer specially formulated to remove mold and mildew) on the top of the sink and around the toilet bowl. Housekeeping placed the cloth rag in a plastic bag on the side of the housekeeping cart for the laundry to wash. On 1/07/2013 at 1:10 PM observation revealed Housekeeping staff B sprayed the dining room tables with a mixture of Lysol and water, and immediately wiped down the tables with a white cloth rag. On 1/09/2013 at 9:30 AM, Housekeeping staff D stated the housekeeping staff clean the residents' room daily with the Lysol and water spray mixture, use the Lemon lift spray and then would dry mop the residents room. Continued interview revealed the housekeeping staff are to wet mop the residents' floors once a week or as needed. On 10/09/2013 at 9:30 AM, Housekeeping staff D stated the housekeeping staff are informed of infections from the nurse, and the resident's room will have a isolation sign on the resident's door. He/she stated if there is an employee who "likes to talk" they will withhold the particular type of virus/bacteria or infection and just inform them to	F 441		

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F 441	Continued From page 18 use isolation precautions. Continued interview revealed the staff are to use Lysol to clean the counters, bed frames, woodwork and Oasis 531(a multi-purpose, neutral pH, germicidal detergent and deodorant) on the floors and for infections to use a bleach concentration of 1 to 10. Housekeeping staff D verified the staff were to use bleach in the bathrooms. The MSDS (Material Safety Data Sheet) revealed the Lysol contained Isopropyl (a solvent used in cleaning products) and Ethanol (alcohol used in cleaning products). The facility's 8/2009 Cleaning and Disinfecting Residents' Rooms directed the housekeeping staff to clean the residents' bathroom sinks and toilets with a disinfectant, and the manufactures instructions will be followed for proper use of disinfecting(or detergent) products. The facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease for the 47 residents in the facility.	F 441		